




DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: DESIGNATED RECORD SET	POLICY NO. 500.5	EFFECTIVE DATE 04/14/03	PAGE 1 of 3
APPROVED BY:  Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 Individuals have the right to inspect, obtain a copy and request amendments to Protected Health Information (PHI) about themselves in a Designated Record Set. The purpose of this policy is to identify those records that comprise the Designated Record Set. Defining the scope of the Designated Record Set is important because it defines the information that is subject to an individual's right to access and amendment.

POLICY

- 2.1 The Department of Mental Health (DMH) will identify those records that comprise the Designated Record Set in order to clarify the access and amendment standards as set forth in the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA).

DEFINITIONS

- 3.1 **"Designated Record Set"** a group of records maintained by or for a covered entity that is:
- Medical and billing records about individuals maintained by or for a covered health care provider;
 - The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; **or**
 - Information used in whole or in part by or for the covered entity to make decisions about individuals.

PROCEDURE

- 4.1 At DMH facilities, Designated Record Sets are maintained by the particular entity that provides medical treatment to the individual.
- 4.1.1 The particular entity controls access to the Designated Record Set.
- 4.1.2 The entity retrieves information from the Designated Record Set by utilizing the name, identifying number, symbol or other identifier assigned to the individual.



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4.2 The Designated Record Set maintained by DMH entities consists of:

4.2.1 Medical Record Designated Record Set includes:

- Documentation of DMH healthcare services provided to an individual in any aspect of healthcare delivery (e.g., advance directives, care plans, consultation reports, discharge summaries, orders, assessments, consents, provider documentation, etc.).
- Individually identifiable data, in any medium, collected or directly used in and/or documenting healthcare or health status. This includes paper-based medical records, imaged records and other electronic/computer-based databases, **and**
- Records of care from all DMH settings, including inpatient and ambulatory areas.

4.2.2 Billing Designated Record Sets include:

- Patient-identifiable claims,
- Other patient identifiable data used for payment purposes, **and**
- DMH supporting documentation for the reimbursement of services provided to the patient.

4.2.3 Records maintained by a business associate that meets the definition of Designated Record Set that are not merely duplicates of information maintained by DMH.

4.3 Exclusions to the Designated Record Set:

The Designated Record Set excludes records that do not pertain to medical treatment, billing, insurance coverage, payment, or claim adjudication, and are not otherwise used to make decisions about the individual. Examples of excluded records include:

4.3.1 “Shadow” records. Files maintained by clinicians that contain only copies of information otherwise located in the Designated Record Set. Shadow records contain no new or original documents and are maintained merely for the convenience of clinicians.

4.3.2 Quality control analysis. Risk management records, quality assessment and improvement records and peer review records that are used for operational analyses and not for making decisions about individuals.

4.3.3 Data collected and maintained for research.

4.3.4 Appointment schedules.



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- 4.3.5 Information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding (e.g., notes taken by DMH during a meeting with DMH's attorney about a pending lawsuit).
- 4.3.6 Employer records (e.g., pre-employment physicals, results of HIV tests on employees who have incurred needle stick injuries on the job).
- 4.3.7 Source data interpreted or summarized in the individual's medical record (e.g., pathology slides, diagnostic films, electrocardiogram tracings from which interpretations are derived).
 - 4.3.7.1 There may be times when an individual has a legitimate need for source data. When such a need arises, DMH shall provide the individual with greater rights of access, allowing the individual access to or copies of the source data when possible.

REFERENCES

Code of Federal Regulations 45 Part 160 and 164; Sections 164.501; 164.524(a)(b)(c)(e); 164.526(a)(b)(c)(d)(e)